Texas Department of Insurance
Division of Workers' Comp
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

DALLAS COUNTY HOSPITAL
P O BOX 660599
DALLAS TX 75260 0599

Respondent Name

NEW HAMPSHIRE INSURANCE CO

Carrier's Austin Representative Box

Box Number 19

MFDR Tracking Number

M4-11-2884-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "CLAIM DID NOT PAY PER DRG"

Amount in Dispute: $15,515.90

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The Requestor billed $51,949.95 and shows on the DWC060 a disputed amount of $15,515.90. The carrier did not make a reimbursement as the bill and information that was submitted lacked information needed to properly audit the bill. The Requestor has furnished information with their request for medical dispute resolution. I did not see an operative report, but we do have that in our claims file. I will submit the information provided by the requestor as well as the operative report to the billing entity for audit and reimbursement. The requestor can dismiss the request for medical dispute resolution when payment is made."

Response Submitted by: Chartis, 4100 Alpha Road, Suite 700, Dallas, Texas 75244

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
November 20, 2010 Through December 6, 2010	Inpatient Hospital Surgical Services	$15,515.90	$7,072.46

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

The Division contacted the requestor's representative, Michelle Hightower via email on August 31, 2011 to ascertain if the respondent had made reimbursement as indicated in their response to the DWC060. Per the requestor's representative, Michelle Hightower, the respondent paid $8,443.44 leaving $7,072.46 remaining in dispute.

The Division contacted the respondent's representative, Neal Moreland, via email on September 20, 2011, requesting a copy of the explanation of benefits reflecting reimbursement to requestor in the amount of $8,443.46. The Division received the requested explanation of benefits via email on September 20, 2011.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for health care providers to pursue a medical fee dispute..
2. 28 Texas Administrative Code §134.404 sets out the guidelines for reimbursement of hospital facility fees for inpatient services.
3. 28 Texas Administrative Code §134.404(e) states that: "Except as provided in subsection (h) of this section, regardless of billed amount, reimbursement shall be:
   (1) the amount for the service that is included in a specific fee schedule set in a contract that complies with the requirements of Labor Code §413.011; or
   (2) if no contracted fee schedule exists that complies with Labor Code §413.011, the maximum allowable reimbursement (MAR) amount under subsection (f) of this section, including any applicable outlier payment amounts and reimbursement for implantables."
   (3) If no contracted fee schedule exists that complies with Labor Code §413.011, and an amount cannot be determined by application of the formula to calculate the MAR as outlined in subsection (f) of this section, reimbursement shall be determined in accordance with §134.1 of this title (relating to Medical Reimbursement).
4. 28 Texas Administrative Code §134.404(f) states that "The reimbursement calculation used for establishing the MAR shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Inpatient Prospective Payment System (IPPS) reimbursement formula and factors as published annually in the Federal Register. The following minimal modifications shall be applied.
   (1) The sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by:
      (A) 143 percent; unless
      (B) a facility or surgical implant provider requests separate reimbursement in accordance with subsection (g) of this section, in which case the facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 108 percent."
5. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated January 3, 2011
   - 1 -16 –Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate.
   - 1 -Please resubmit your bill with one or more of the following records that pertain to your bill: Operative report, discharge summary, itemized bill, anesthesia records, diagnostic reports, medical reports. Please attach a copy of this EOR with your resubmission. (X473)
   - * - Any request for reconsideration of this workers' compensation payment should be accompanied by a copy of this explanation of review. (Z656)

   Explanation of benefits dated January 10, 2011
   - 1 - 18 –Duplicate claim/service.
   - 1 - This item was previously submitted and reviewed with notification of decision issued to payor, provider (duplicate invoice.) (U301)
   - * -Please resubmit your bill with one or more of the following records that pertain to your bill: Operative report, discharge summary, itemized bill, anesthesia records, diagnostic reports, medical reports. Please attach a copy of this EOR with your resubmission. (X473)
   - * - Previously requested information/documentation has not been received. (X022)

   Explanation of benefits dated January 25, 2011
   - 1 - 18 –Duplicate claim/service.
   - 1 - This item was previously submitted and reviewed with notification of decision issued to payor, provider (duplicate invoice.) (U301)
   - * - Please resubmit your bill with one or more of the following records that pertain to your bill: Operative report, discharge summary, itemized bill, anesthesia records, diagnostic reports, medical reports. Please attach a copy of this EOR with your resubmission. (X473)

Explanation of benefits dated February 28, 2011

- 1 - 18 –Duplicate claim/service.
- 1 - This item was previously submitted and reviewed with notification of decision issued to payor, provider (duplicate invoice.) (U301)

Explanation of benefits dated March 8, 2011

- 1 - 45 –Charges exceed your contracted/legislated fee arrangement.
- 1 - The payer denies this charge as the statute of limitations has been exceeded. (X960)
- * - Any request for reconsideration of this workers' compensation payment should be accompanied by a copy of this explanation of review. (Z656)

Explanation of benefits dated June 4, 2011

- 1 – W1 –Workers Compensation State Fee Schedule Adjustment.
- 1 – No Reduction Available. (VRNA)
- * - Any request for reconsideration of this workers' compensation payment should be accompanied by a copy of this explanation of review. (Z656)

Issues

1. Were the disputed services subject to a specific fee schedule set in a contract between the parties that complies with the requirements of Labor Code §413.011?
2. Can the maximum allowable reimbursement (MAR) amount for the disputed services be determined according to 28 Texas Administrative Code §134.404(f)?
3. Did the facility or a surgical implant provider request separate reimbursement for implantables in accordance with 28 Texas Administrative Code §134.404(g)?
4. Did the respondent support denial reason code '16'?
5. Did the respondent support denial reason code '18'?
6. Is the requestor entitled to reimbursement for the disputed services?

Findings

1. The respondent denied reimbursement for the disputed service based upon "Charges exceed your contracted/legislated fee arrangement." 28 TAC §133.3 requires that "Any communication between the health care provider and insurance carrier related to medical bill processing shall be of sufficient, specific detail to allow the respondent to easily identify the information required to resolve the issue or question related to the medical bill. Generic statements that simply state a conclusion such as 'insurance carrier improperly reduced the bill' or 'health care provider did not document" or other similar phrases with no further description of the factual basis for the sender's position does not satisfy the requirements of this section." The Division finds that the denial reason is generic because it does not identify where a contract was accessed, nor does it identify the network if indeed a discount was taken due to a contract. The respondent did not clarify or otherwise address the 45 claim adjustment code upon receipt of the request for dispute resolution. For this reason, the Division finds that the 45 claim adjustment code is not supported.
2. Review of the submitted documentation finds that the maximum allowable reimbursement (MAR) amount for the disputed services can be determined according to 28 Texas Administrative Code §134.404(f).
3. Review of the submitted documentation finds no request for separate reimbursement of implantables in accordance with 28 Texas Administrative Code §134.404(g).
4. The respondent denied reimbursement based upon claim/service lacks information needed for adjudication. 28 TAC §133.3 requires that "Any communication between the health care provider and insurance carrier related to medical bill processing shall be of sufficient, specific detail to allow the respondent to easily identify the information required to resolve the issue or question related to the medical bill. Generic statements that simply state a conclusion such as 'insurance carrier improperly reduced the bill' or 'health care provider did not document" or other similar phrases with no further description of the factual basis for the sender's position does not satisfy the requirements of this section." The Division finds that the respondent specifically requested the operative report, discharge summary, itemized bill, anesthesia records, diagnostic reports and medical reports needed for adjudication. For this reason, the Division finds that the 16 claim adjustment code is supported.
5. The Respondent denied reimbursement based upon duplicate claim/service. The disputed service was a duplicate bill submitted for reconsideration of payment. The Respondent did not provide information/documentation of duplicate payments. Therefore, this payment denial reason has not been supported.

6. Reimbursement for the disputed services is calculated in accordance with 28 TAC §134.404(f)(1)(A) as follows:

   The Medicare facility-specific reimbursement amount including outlier payment amount for DRG 301 is $10,850.28.

   This amount multiplied by 143% is $15,515.90.

   The total maximum allowable reimbursement (MAR) is $15,515.90.

   This amount less the amount previously paid by the respondent of $8,443.44 leaves an amount due to the requestor of $7,072.46.

   The Division concludes that the requestor is entitled to $7,072.46 additional reimbursement.

Conclusion

For the reasons stated above, the division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $7,072.46.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $7,072.46 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	September 23, 2011 Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division rule at 28 Texas Administrative Code §148.3(c).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.